

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06314

Reg. Dist. No.

6373

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Allegany</b> b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital, D. O. A.</b>				d. STREET ADDRESS <b>801 Hilltop Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Frank J. Beachley</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-29-88</b>	9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steam Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset Co. Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Ira Beachley</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Queer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>801 Hill Top Drive Mrs. Annie Beachley Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Liver, Crushed Chest</b>              DUE TO              Conditions, if any, which gave rise to immediate cause (b) <b>Automobile Accident</b>              (c), stating the underlying cause lost. (c)</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>30 Min.</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>					
20c. TIME OF INJURY Month, Day, Year <b>9.20 6/28/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Near Cumberland. Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. Skitarelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 28, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Beachdale</b>		22d. LOCATION (City, town, or county) (State) <b>R.D.1 Garrett, Somerset, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.A. Johnson</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Beach</b>	

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Environ Biol Fish (2015) 98:1171–1181

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6374

## CERTIFICATE OF DEATH

Reg. Dist. No.

06315

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>H.</b> Last <b>BENDER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-1901</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rinzel Restaurant Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. Hardy</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stutzman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>165-22-4785</b>	
17. INFORMANT <b>Bruce J. Bender, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1958</b> , to <b>6/25</b> , 1958, that I last saw the deceased alive on <b>6/25</b> , 1958, and that death occurred at <b>5:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Broadway</b> DATE SIGNED <b>6/25/58</b>			
ACTUAL SIGNATURE <b>Martin Rothstein, M.D.</b> M.D. <b>48 Broadway</b>		DATE SIGNED <b>6/25/58</b>	
PHYSICIAN'S NAME (Type) <b>Martin Rothstein, M. D.</b>		<b>Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-28-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Durst</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove extra papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH



6320  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>HAMPSHIRE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>26 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>R.</b> Last <b>BIDENGER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>28</b> Year <b>19 58.</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 15,</b>	
9. AGE (In years lost birthday) yrs. <b>77</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>FORT ASHBY, W. VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>GEORGE BIDENGER</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA CRAWFORD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line of (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592x</b> DUE TO <b>Chronic nephritis with Uremia.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b> <b>Anemia - secondary</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>6-2-58</b> , 19 <b>58</b> , to <b>6-28-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-28-58</b> , 19 <b>58</b> , and that death occurred on <b>6-28-58</b> , 19 <b>58</b> , at <b>10:00 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1225 Center St, Cumberland, Md</b> DATE SIGNED <b>6-30-58</b> ACTUAL SIGNATURE <b>Howard L. Tolson</b> PHYSICIAN'S NAME (Type) <b>DR. HOWARD L. TOLSON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>July 1</b>		<b>Springfield Hill</b>		<b>Springfield W. Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Keith S. Soper</b>				ADDRESS <b>Remney W. Va</b>		24a. REC'D BY REGISTRAR DATE <b>July 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Soper</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEST VIRGINIA

20 DAYS

20 DAYS

MEMORIAL HOSPITAL

1913

1913

1913

DECEMBER 11

DECEMBER 11

DECEMBER 11

FORT ANDERSON, W. VA.

DECEMBER 11

DECEMBER 11

Chronic nephritis with uremia

arteriosclerosis - coronary

1913

1913

1913

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 6375 CERTIFICATE OF DEATH

06317

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main St.</u>				STREET ADDRESS <u>Main St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Rose L. Broderick</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 5 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 12, 1879</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George M. McWilliams</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Whitehair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic</u>						<u>5 Years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Pulmonary Edema</u>		<u>1 Day</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>June 4, 1958</u>, to <u>June 5, 1958</u>, that I last saw the deceased alive on <u>June 4, 1958</u>, and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.</b>							
SIGNATURE <u>Paul R. Wilson</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>Ashfield St. Piedmont, W. Va. 6-5-58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/9/58</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Piedmont, W. Va.</u>	

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# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

REG. NO. 12

1. NAME OF DECEASED (Print or Write)

Allegory

Male

Married

Allegory

Westport

Westport

Male

Male

June 2

October 1

Wood

78

52.12.1973

Widow

Female, White

and home

Home-ville

Widow

George W. Williams

2. MEDICAL HISTORY (Print or Write)

3. CAUSE OF DEATH (Print or Write)

CHRONIC DISEASE

HEART DISEASE

POSSIBLE OF CHRONIC DISEASE

CAUSE OF DEATH

CHRONIC DISEASE

POSSIBLE OF CHRONIC DISEASE

CAUSE OF DEATH

CHRONIC DISEASE

POSSIBLE OF CHRONIC DISEASE

CAUSE OF DEATH

CHRONIC DISEASE

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CAUSE OF DEATH

CHRONIC DISEASE

POSSIBLE OF CHRONIC DISEASE

CAUSE OF DEATH

CHRONIC DISEASE

POSSIBLE OF CHRONIC DISEASE

CAUSE OF DEATH

4. SIGNATURE OF PHYSICIAN (Print or Write)

6/2/78

Chief

Baltimore, Md.

5. PLACE OF DEATH (Print or Write)

6. DATE OF DEATH (Print or Write)

7. TIME OF DEATH (Print or Write)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6321

CERTIFICATE OF DEATH

06318

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>3 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 Mullin Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Helen</b> <b>Burke</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1876</b>		9. AGE (In years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Handel</b>				14. MOTHER'S MAIDEN NAME <b>Christine Barnhart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>one</b>		17. INFORMANT <b>Mrs. Dwight Proudfoot</b> <b>Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis</b> (c) <b>Arteriosclerotic C.V. Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b> <b>5 yrs</b> <b>8 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 27, 1958</b> to <b>June 28, 1958</b> , that I last saw the deceased alive on <b>June 27, 1958</b> , and that death occurred at <b>9:10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clay E. Durrett</b> M.D.				ADDRESS (Street, city or town, state) <b>236 Va. Ave. Cumberland, Md.</b> DATE SIGNED <b>7/1/58</b>			
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett</b> M.D. <b>2366</b>				<b>Virginia Avenue, Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6351

Name of Deceased [Illegible]		Date of Death [Illegible]	
Sex [Illegible]		Age [Illegible]	
Race [Illegible]		Place of Birth [Illegible]	
Usual Residence [Illegible]		Address at Time of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]	
Physician's Name [Illegible]		Signature of Physician [Illegible]	
Date of Report [Illegible]		Signature of Registrar [Illegible]	



6322

CERTIFICATE OF DEATH

Reg. Dist. No. 06319

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>38 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>309 East Oldtown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>B.</b> Last <b>Callis</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting Contractor Hoyes, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Callis</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Deahl</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>214-05-6729</b>	
17. INFORMANT <b>Mrs. Charles B. Callis, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive Heart Failure</b> DUE TO <b>Art. C. V. D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Art. C. V. D.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 58</b> , to <b>6-24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-24</b> , 19 <b>58</b> , and that death occurred at <b>2:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 Bedford St. Cumberland, Md.</b> DATE SIGNED <b>6/25/58</b>			
ACTUAL SIGNATURE <b>Thomas F. Lusby</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Thomas F. Lusby 121 Bedford St. Cumberland, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 28, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 27 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Quincy</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Fil-6230 6-30-58 et

6323

## CERTIFICATE OF DEATH

06320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>28 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>P</b> Last <b>CARPENTI</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MAY 12, 1920</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady Shoes Dept. Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND Cumberland U.S.A.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>IRA BUCY</b>		14. MOTHER'S MAIDEN NAME <b>PEARL REED</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>0580797</b>	
17. INFORMANT <b>Memorial Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung c</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastasis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>9 mon</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 1957</b> to <b>6/22</b> , 1958, that I last saw the deceased alive on <b>6/22</b> , 1958, and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>128 Union St Cumberland Md</b> DATE SIGNED <b>6/22/58</b> ACTUAL SIGNATURE <b>George M. Simons</b> M.D. PHYSICIAN'S NAME (Type) <b>DR GEORGE M. SIMONS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-25-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>RestLawn Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1412/14

1712-1713

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06321

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>15 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY ELIZABETH CLAY</b>		4. DATE OF DEATH Month Day Year <b>JUNE 3 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 55, 1883 74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND Little Orleans U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jonas POTTS</b>		14. MOTHER'S MAIDEN NAME <b>Mary Keefer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic carcinoma from</b> DUE TO (c) <b>carcinoma of left kidney</b> INTERVAL BETWEEN ONSET AND DEATH <b>one week</b> <b>indefinite</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic passive congestion of liver</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 18, 1958</b> , to <b>June 3, 1958</b> , that I lost saw the deceased alive on <b>June 3, 1958</b> , and that death occurred at <b>11:40 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas F. Lewis</b>		ADDRESS (Street, city or town, state) <b>Hotel Algonquin</b>	
PHYSICIAN'S NAME (Type) <b>DR. THOMAS LEWIS</b>		DATE SIGNED <b>Cumberland Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Patrick Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. F. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH July 1, 1918		6. PLACE OF DEATH Home	
7. CITY Baltimore		8. COUNTY Baltimore	
9. STATE Maryland		10. MANNER OF DEATH Natural	
11. CAUSE OF DEATH Pneumonia		12. MEDICAL HISTORY None	
13. SIGNATURE OF PHYSICIAN J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris	
15. SIGNATURE OF DECEASED J. H. Harris		16. SIGNATURE OF NEAREST RELATIVE J. H. Harris	
17. SIGNATURE OF CLERK J. H. Harris		18. SIGNATURE OF REGISTRAR J. H. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 230 6-16-58 et

CERTIFICATE OF DEATH

06322

Reg. Dist. No.

6392

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oldtown, Md.</b>		c. LENGTH OF STAY IN 1b <b>21 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rd #1</b>		e. STREET ADDRESS <b>/ Rd #1</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Hott</b> Last <b>Crabtree</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1906</b> <b>May 26, 1906</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Hours <b>10</b> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Shanks, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Silas Hott</b>		14. MOTHER'S MAIDEN NAME <b>Florence Sirbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Gilbert Crabtree, Oldtown, Md.</b>		Address <b>Rt #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General malnutrition and toxemia</b> DUE TO <b>Go</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, Cervix with metastases</b> DUE TO <b>2 yrs</b> (c) -----		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>9</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1958</b> , to <b>June 6, 1958</b> , that I last saw the deceased alive on <b>June 19, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>Carlton Brinsfield</b> M.D. PHYSICIAN'S NAME (Type) <b>CARLTON BRINSFIELD</b> <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Oldtown, Allegany Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Parks Funeral H. Berkeley Spgs, W. Va.</b>		24a. REC'D BY REGISTRAR <b>JUN 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Red Smith</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES J. JONES		M		45		W		1910		NEW YORK		1955		NEW YORK		HEART DISEASE		NATURAL		J. J. JONES		J. J. JONES	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
MANAGER		HIGH SCHOOL		CATHOLIC		MARRIED		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

## CERTIFICATE OF DEATH

06323

Reg. Dist. No.

6325

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Caudy</u> Last <u>Crawford</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/16/84</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wall Paper</u>	
11. BIRTHPLACE (State or foreign country) <u>Fort Ashby, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Scott Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Sally Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Miss Nellie Crawford Ft. Ashby, W. Va.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic and Hypertensive Ht. Dmn</u> DUE TO (c) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Instantly</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia due to nephrosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/20</u> , 19 <u>58</u> , to <u>6/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/2</u> , 19 <u>58</u> , and that death occurred at <u>2:25 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Fort Ashby, W. Va.</u> DATE SIGNED <u>6/3/58</u>			
ACTUAL SIGNATURE <u>A. Weissman</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. S.G. Weisman</u> <u>59 Greene Street Cumberland, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fort Ashby, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.  
K 652 COM FNA

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06324

Reg. Dist. No.

6326

FOR STATE  
HEALTH DEPT.

### 1. PLACE OF DEATH

#### a. COUNTY

Allegany

MARYLAND

#### b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

#### c. LENGTH OF STAY IN 1b

54yrs

### 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

#### a. STATE

Maryland

#### b. COUNTY

Allegany

#### c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland, Md. 02

#### d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. Memorial Hospital

#### d. STREET ADDRESS

413 Race Street

#### e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

Elizabeth Etta Cunningham

### 4. DATE OF DEATH

Month Day Year  
6 - 8 - 19 58

#### 5. SEX

Female

#### 6. COLOR OR RACE

White

#### 7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

#### 8. DATE OF BIRTH

July 9, 1888

#### 9. AGE (In years last birthday)

69 yrs.

#### IF UNDER 1 YEAR

Months Days Hours Min.

#### IF UNDER 24 HRS.

Hours Min.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self Employed

### 10b. KIND OF BUSINESS OR INDUSTRY

Grocery Store

### 11. BIRTHPLACE (State or foreign country)

Artemas, Pa.

### 12. CITIZEN OF WHAT COUNTRY?

USA

### 13. FATHER'S NAME

Samuel Jay

### 14. MOTHER'S MAIDEN NAME

Agnes Barkman

### 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

### 16. SOCIAL SECURITY NO.

212-32-8094

### 17. INFORMANT

### Address

Dr. Orville Swartley, Cumberland, Md.

### 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

#### PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420.0

#### DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

#### DUE TO

#### (c)

Acute Heart Failure

(b) Arteriosclerotic heart disease

### INTERVAL BETWEEN ONSET AND DEATH

6 hrs.

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

### 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

### 20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

### 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

### 20c. TIME OF INJURY

Month, Day, Year  
Hour a. m. p. m.

### 20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

### ACTUAL SIGNATURE

Benedict Skitarelic

### M.D.

### CHIEF MEDICAL EXAMINER ☐

### DATE SIGNED

### EXAMINER'S NAME (Type)

Dr. Benedict Skitarelic

### ASSISTANT MEDICAL EXAMINER ☐

### DEPUTY MEDICAL EXAMINER ☒

May 8, 1958

### 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 22b. DATE THEREOF

6-11-58

### 22c. NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

### 22d. LOCATION (City, town, or county)

Cumberland, Md.

### (State)

### 23. FUNERAL DIRECTOR'S SIGNATURE

### ADDRESS

James F. Scarpelli, Cumberland, Md.

### 24a. REC'D BY REGISTRAR

DATE JUN 10 '58

### 24b. REGISTRAR'S SIGNATURE

Artemas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## . MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6327

## CERTIFICATE OF DEATH

06325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>1 1/2 HRS.</b>		d. STREET ADDRESS <b>RT. #1, VALLEY ROAD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES R. DICK</b>		4. DATE OF DEATH Month Day Year <b>JUNE 22 19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 30, 1921</b>
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FORD GARAGE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN C. DICK</b>		14. MOTHER'S MAIDEN NAME <b>RUTH I. HAUSMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW11		16. SOCIAL SECURITY NO. <b>215-16-4464</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 445x DUE TO <b>Malignant Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>7 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 - 12</b> , 19 <b>56</b> , to <b>6 - 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6 - 21</b> , 19 <b>58</b> , and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Greene St. Cumberland, Md.</b> DATE SIGNED <b>6-22-58</b>			
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>		M.D. <b>62 Greene St. Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>DR. RALPH BALLIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 25, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John . Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 27 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

CERTIFICATE OF DEATH

1937

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06326

6328

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>6 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>ELMER</b> Last <b>DIEBOLD</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <b>KK</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 17, 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY DIEBOLD (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Lewis (DECEASED)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WWI</b>	
17. INFORMANT <b>PATIENTS CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myocarditis, generalized</b> DUE TO (c) <b>Coronary Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 da.</b> <b>10 yr.</b> <b>10 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity, marked</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 28, 1958</b> , to <b>June 17, 1958</b> , that I last saw the deceased alive on <b>June 17, 1958</b> , and that death occurred at <b>2:50 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Hallinan M.D.</b>		ADDRESS (Street, city or town, state) <b>140 BEDFORD ST., CUMBERLAND, MD.</b> DATE SIGNED <b>6/17/58</b>	
PHYSICIAN'S NAME (Type) <b>JAMES P. HALLINAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6/20/58</b>	
24b. REGISTRAR'S SIGNATURE <b>Paula</b>			

8

5

[illegible]

## STANDARD PRINTING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6329

CERTIFICATE OF DEATH

06327

Reg. Dist. No.

1. PLACE OF DEATH a. <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXXX</del> <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>21 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>EDITH</b> Last <b>DIETZ</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>23</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 18</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALEXANDRA EMERICK</b>		14. MOTHER'S MAIDEN NAME <b>CLARA KENNEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL - MEMORIAL &amp; WARWICK AVES.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Sarcoma</b> <b>158x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Intermittent</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22, 1958</b> to <b>June 23, 1958</b> , that I last saw the deceased alive on <b>June 22, 1958</b> , and that death occurred at <b>12:31 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William P. James</b>		ADDRESS (Street, city or town, state) <b>441 N. Center St</b>	
NAME (Type) <b>William P. James, M.D.</b>		DATE SIGNED <b>6-23-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 25, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md. RD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Zeigler</b>		ADDRESS <b>Hyndman, Pa.</b>	
24a. REC'D BY REGISTRAR <b>JUN 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 1-10

SUBJECT

MR. BARNES

ST. JOHNS HOSPITAL

GENERAL

53

311

DECEASED

WHITE

MALE

AGE

1910

WHITE

MALE

1910

DECEASED

ST. JOHNS HOSPITAL

ST. JOHNS HOSPITAL - DECEASED & BARNES, MR.

1910

ST. JOHNS HOSPITAL - DECEASED & BARNES, MR.

1910

ST. JOHNS HOSPITAL - DECEASED & BARNES, MR.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6330

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>610 Memorial Avenue</u>			d. STREET ADDRESS <u>610 Memorial Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>WILBUR JAMES DIXON</u>			4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Supervisor B &amp; O Glenmore, New York</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Adomson Dixon</u>			14. MOTHER'S MAIDEN NAME <u>Eunice Stanford</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Anna K. Dixon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>June 24, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 28, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Westmoreland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westmoreland, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6376

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>(ARTZ)</b> Last <b>DREW</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-1887</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR: Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Artz</b>		14. MOTHER'S MAIDEN NAME <b>Annie Chilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Harbert Allen, Rt. 1, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>443X</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Septicemia</b> (c) <b>Septicemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b> <b>Septicemia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b> <b>Septicemia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 1</b> , 19 <b>58</b> , to <b>June 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 26</b> , 19 <b>58</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b> DATE SIGNED <b>June 27 1958</b>			
ACTUAL SIGNATURE <b>W. O. McLane M.D.</b>		PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-29-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Durst</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6370

WILLIAM DONALD

AGE 35

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

6377

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			c. LENGTH OF STAY IN 1b <b>10 hrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>Box 94, Carlos</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>JANE</b> Last <b>DREW</b>				4. DATE OF DEATH Month <b>6</b> Day <b>8</b> Year <b>19 58.</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-23-1894</b>	
9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Carlos, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Daniel Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Alice Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Harold Drew, Box 94 (Carlos) Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> <b>422.1</b> DUE TO <b>Cardiovascular Disease - 10.2 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus, uncontrolled</b> 1 month (c) <b>12 hrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>260x</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> Month, Day, Year p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1958</b> , to <b>June 8, 1958</b> , that I last saw the deceased alive on <b>June 8, 1958</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 B Roadway Frostburg, Md.</b> DATE SIGNED <b>6/9/58</b>							
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>John B. Davis, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montecant</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
1937  
CERTIFICATE OF DEATH

1. Name of deceased: *John A. Smith*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *Jan 15, 1892*  
5. Place of birth: *St. Louis, Mo.*  
6. Usual residence: *1234 N. Main St., Baltimore, Md.*  
7. Cause of death: *Myocardial infarction*  
8. Date of death: *Dec 10, 1937*  
9. Time of death: *10:15 AM*  
10. Place of death: *Home*  
11. Signature of physician: *Dr. J. H. Jones*  
12. Signature of registrar: *John A. Smith*  
13. Signature of informant: *John A. Smith*  
14. Signature of undertaker: *John A. Smith*  
15. Signature of funeral home: *John A. Smith*  
16. Signature of cemetery: *John A. Smith*  
17. Signature of burial place: *John A. Smith*  
18. Signature of interment: *John A. Smith*  
19. Signature of burial place: *John A. Smith*  
20. Signature of interment: *John A. Smith*



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06331

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>225 Columbia Street</u>			d. STREET ADDRESS <u>1 225 Columbia St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Josephine H. Edwards</u>			4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 30, 1880</u>		9. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Flintstone, Alleg. Co. N. S. A.</u>	
13. FATHER'S NAME <u>William F. Willison</u>			14. MOTHER'S MAIDEN NAME <u>Elmira Hendrickson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Webster Edwards</u> Address <u>Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C V disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Acute and Chronic Cholecystitis</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 16, 1958</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelis</u>		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>	
22d. LOCATION (City, town, or county) <u>Frostburg Md</u>		(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>JUN 18 '58</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6332

06332

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>C.</b> Last <b>ESKIN</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 9, 1908</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>NEWARK, N.J.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>CARL ESKIN</b>				14. MOTHER'S MAIDEN NAME <b>ROSE Saslow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>212-38-6539</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident --- Hemorrhage right</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>side with Paralysis left side of body.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>June 22</b> , 19 <b>58</b> , to <b>June 25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 25</b> , 19 <b>58</b> , and that death occurred at <b>11:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing Street</b> DATE SIGNED <b>6/26/58</b>							
ACTUAL SIGNATURE <i>[Signature]</i> M.D.				PHYSICIAN'S NAME (Type) <b>DR. S. JACOBSON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>June 27, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East View Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>	
24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FOR EXAMINING PHYSICIAN

3 DAYS

CERTIFICATE

STATE HOSPITAL

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6333

## CERTIFICATE OF DEATH

06333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 DAY;</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X LAVALE</b> d. STREET ADDRESS <b>Maple St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BESSIE Franklin EWALD</b>		4. DATE OF DEATH Month Day Year <b>JUNE 11 19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 22, 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND Balto.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM F. GEES</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE Dunningan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sharp</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-10-1958</b> , to <b>6-11-1958</b> , that I last saw the deceased alive on <b>6-11-1958</b> , and that death occurred at <b>6:11 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. F. Williams</b> M.D. <b>Cumberland Md.</b> <b>6-12-58</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b> <b>122 S. Centre St.,</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/13/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. George Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Allen Smith</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

1933

NAME OF DECEASED WILLIAM F. DEER		AGE 1 DAY	
SEX MALE		RACE WHITE	
DATE OF BIRTH JANUARY 1, 1933		PLACE OF BIRTH BALTIMORE, MARYLAND	
DATE OF DEATH JANUARY 2, 1933		PLACE OF DEATH BALTIMORE, MARYLAND	
TIME OF DEATH 11:00 AM		CAUSE OF DEATH RESPIRATORY DISTRESS	
MANNER OF DEATH NATURAL		DISEASE OR INJURY PNEUMONIA	
SIGNATURE OF PHYSICIAN DR. W. F. WILLIAMS		SIGNATURE OF CORONER J. H. BROWN	
DATE JANUARY 2, 1933		PLACE BALTIMORE, MARYLAND	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6335

## CERTIFICATE OF DEATH

Reg. Dist. No.

06335

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>KX 1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BABY GIRL GRAPES</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6.28.58</b>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT E. GRAPES</b>		14. MOTHER'S MAIDEN NAME <b>VIVIAN RYAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity 28 wks. c. techniques</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 June, 1958</b> , to <b>29 June 1958</b> , that I last saw the deceased alive on <b>29 June 1958</b> , and that death occurred at <b>9:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Fuller B. Whitworth</b>		ADDRESS (Street, city or town, state) <b>Cumberland Md</b>	
PHYSICIAN'S NAME (Type) <b>Fuller B. Whitworth</b>		DATE SIGNED <b>30 June 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hefer, Cumberland, Md</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUL 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. ...</b>	



6336

CERTIFICATE OF DEATH

Reg. Dist. No. 06336

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>16 HOURS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>11X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>JENI</u> Middle <u>RAE</u> Last <u>GREEN</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 29, 1958</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ROBERT BLAINE GREEN</u>				14. MOTHER'S MAIDEN NAME <u>HAZEL V. KNOX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>PATIENTS CHART</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/4</u> , 19 <u>58</u> , to <u>6/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>58</u> , and that death occurred at <u>3:20A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Elizabeth Brings</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ELIZABETH BRINGS, M.D.</u>				<u>55 GREENE ST., CUMBERLAND, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>GRANTSVILLE GARRETT CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman Grantsville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

## STATE OF NEW YORK STATE DEPARTMENT OF HEALTH-BUFFALO 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6337

## CERTIFICATE OF DEATH

Reg. Dist. No.

06337

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 HRS. 8 MINS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BABY BOY HARBAUGH</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>10</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 10, 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND</b>	
13. FATHER'S NAME <b>THOMAS E. HARBAUGH</b>		14. MOTHER'S MAIDEN NAME <b>BETTY D. KERNS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>756.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Herniation of Abdominal Viscera into Left Chest</b> (c) <b>Complete Absence of Left Diaphragm</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Complete Absence of Left Diaphragm</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 June 19 58</b> , to <b>10 June 19 58</b> , that I last saw the deceased alive on <b>10 June 19 58</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>63 Greave St, Cumb Md</b> DATE SIGNED <b>12 June 58</b>			
ACTUAL SIGNATURE <b>Leland Ransom</b> M.D.			
PHYSICIAN'S NAME (Type) <b>DR. LELAND RANSOM</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 11, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Ransom</b>	

CERTIFICATE OF DEATH

8337

NAME [Illegible]		SEX [Illegible]		AGE [Illegible]	
RACE [Illegible]		OCCUPATION [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF WITNESS [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF CORONER [Illegible]		NAME OF WITNESS [Illegible]	
ADDRESS OF PHYSICIAN [Illegible]		ADDRESS OF CORONER [Illegible]		ADDRESS OF WITNESS [Illegible]	
CITY OF PHYSICIAN [Illegible]		CITY OF CORONER [Illegible]		CITY OF WITNESS [Illegible]	
STATE OF PHYSICIAN [Illegible]		STATE OF CORONER [Illegible]		STATE OF WITNESS [Illegible]	
COUNTY OF PHYSICIAN [Illegible]		COUNTY OF CORONER [Illegible]		COUNTY OF WITNESS [Illegible]	
ZIP CODE OF PHYSICIAN [Illegible]		ZIP CODE OF CORONER [Illegible]		ZIP CODE OF WITNESS [Illegible]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06338**

**6338**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>10 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>W.</b> Last <b>Hartsock</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/7/96</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ensley Hartsock</b>		14. MOTHER'S MAIDEN NAME <b>Clara W. Willison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 24 6029</b>		17. INFORMANT <b>Patients Chart</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-11</b> , 19 <b>54</b> , to <b>6-4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-4</b> , 19 <b>58</b> , and that death occurred at <b>2:50 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Greens St.</b> DATE SIGNED <b>6-5-58</b> ACTUAL SIGNATURE <b>Ralph W. Ballin</b> M.D. <b>62 Greens St.</b> PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b> <b>Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 7, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 9 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Albert...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6393

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>S.</b> Last <b>HENCKEL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 1, 1869</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Valentine Henckel</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Miss Grace Henckel, Mt. Savage, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Left Hemiplegia</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6, 1958</b> to <b>June 6, 1958</b> , that I last saw the deceased alive on <b>June 6, 1958</b> and that death occurred at <b>10:45 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. O. McLane</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>E. Main St., June 7, 1958</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-9-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6394

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. 1 Barton, Md.</b>				c. LENGTH OF STAY IN 1b <b>7 yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. 1 Barton, Md.</b>				d. STREET ADDRESS <b>R.F.D. 1 Barton, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 1 Barton, Md</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EXENIA</b> First <b>BELLE</b> Middle <b>HILL</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 2, 1878</b>	
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Delaplain Moreland</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kay</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Allen Hill</b>		Address <b>Piedmont, W.Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Edema</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 Years</b> <b>10 Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 3, 1958</b> , to <b>June 3, 1958</b> , that I last saw the deceased alive on <b>June 3, 1958</b> , and that death occurred at <b>9:11</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul R. Wilson</b> M.D.				ADDRESS (Street, city or town, state) <b>Piedmont W.Va</b>		DATE SIGNED <b>6-4-58</b>	
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 5, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sharps Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fair Hill Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Boral</b> ADDRESS <b>Westernport, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. Boral</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6339

## CERTIFICATE OF DEATH

06341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		c. LENGTH OF STAY IN TB <b>65 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>HIRSH</b> Last <b>HIRSH</b>		4. DATE OF DEATH Month <b>6</b> Day <b>30</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/3/1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>28</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>28</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HIRSH, JOSEPH</b>		14. MOTHER'S MAIDEN NAME <b>*BAMBERGER, LINA Bamberger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-30-8347</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Fibrosis and Coronary Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Calcified Aorta</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>15 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 26</b> , 19 <b>58</b> , to <b>June 30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>58</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing St.</b> DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. PHYSICIAN'S NAME (Type) <b>DR. S. M. JACOBSON</b> <b>Cumberland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>East View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '58</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Eduech</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERIOD OF ILLNESS

PERIOD OF INCUBATION

PERIOD OF LATENCY

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF DECEASED

NAME OF WITNESS

DATE OF DEATH

PLACE OF DEATH

NAME OF PHYSICIAN

NAME OF NURSE

DATE OF EXAMINATION

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF EXAMINATION

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PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6340

## CERTIFICATE OF DEATH

06342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>157 Polk Street</u>		d. STREET ADDRESS <u>157 Polk Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Thomas</u> Last <u>Hoban</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Allegany Bulletin</u>	11. BIRTHPLACE (State or foreign country) <u>Conaoning Md</u>
13. FATHER'S NAME <u>Thomas J. Hoban</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-30-1510</u>	17. INFORMANT Address <u>Mrs. Nellie Hoban Cumb Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u> <u>3 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>p. m.</u> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>February 24, 1958</u> to <u>June 23, 1958</u> , that I last saw the deceased alive on <u>June 23, 1958</u> , and that death occurred at <u>1:55 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Hallinan M.D.</u>		ADDRESS (Street, city or town, state) <u>140 Beafora St.</u> DATE SIGNED <u>6-24-58</u>	
PHYSICIAN'S NAME (Type) <u>James P. Hallinan M. D.</u>		<u>Cumberland, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/24/58</u>	<u>St. Patricks</u>	<u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		24a. REC'D BY REGISTRAR <u>June 26 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10



6378

CERTIFICATE OF DEATH

Reg. Dist. No.

06343

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u>				c. LENGTH OF STAY IN 1b <u>12 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MINERS HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>HOBEL</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 5-1958</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DAVID E. HOBEL</u>				14. MOTHER'S MAIDEN NAME <u>CAROLYN KAY KIRK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>FATHER</u>		Address <u>RT #1 FROSTBURG - MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PLACENTA PREVIA - LATERALIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JUNE 5, 1958</u> , to <u>JUNE 5, 1958</u> , that I last saw the deceased alive on <u>JUNE 5, 1958</u> , and that death occurred at <u>7:28 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin W. Rothstein M.D.</u> M.D.						ADDRESS (Street, city or town, state) <u>48 BRADDAWAY</u> DATE SIGNED <u>6/5/58</u>	
PHYSICIAN'S NAME (Type) <u>MARTIN W. ROTHSTEIN M.D.</u> <u>FROSTBURG MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONACONING - CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CONACONING MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David E. Hobel</u>				ADDRESS <u>RT #1, FROSTBURG MD.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>			

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## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6379

## CERTIFICATE OF DEATH

Reg. Dist. No.

06344

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Westernport</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>43 Westernport</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>207 Hammond</b>		d. STREET ADDRESS <b>1 207 Hammond</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elsie</b> First <b>Belle</b> Middle <b>Howe</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>David Ravenscroft</b>		14. MOTHER'S MAIDEN NAME <b>Mary Whorrey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>William Howe</b>	
17. INFORMANT <b>William Howe</b>		Address <b>Westernport, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>old posterior infarction</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 27, 1958</b> , to <b>June 19, 1958</b> , that I last saw the deceased alive on <b>June 15, 1958</b> , and that death occurred at <b>11:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Piedmont, W. Va.</b> DATE SIGNED <b>June 24, 1958</b>			
ACTUAL SIGNATURE <b>Paul R. Wilson</b> M.D.		PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Nethkin Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Elk Garden W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ES. Bond</b>		ADDRESS <b>Westernport, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Ch. Reed</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

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ISM 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6341

## CERTIFICATE OF DEATH

06345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN TB <u>61 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>519 Washington St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Jacob</u> Last <u>Jacob</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh A. McMullen</u>		14. MOTHER'S MAIDEN NAME <u>Anna Mulledy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William C. Jacob</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>170x</u> DUE TO <u>LUNGS, LIVER, CARCINOMATOSIS, GENERAL, PLEURA</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. DUE TO <u>Adenocarcinoma left breast removed Oct 1956</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>June 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>58</u> , and that death occurred at <u>11:55</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>59 Greene St</u> DATE SIGNED <u>6/6/58</u> ACTUAL SIGNATURE <u>Alweisman</u> M.D. <u>  </u> PHYSICIAN'S NAME (Type) <u>S O WEISTMAN</u> <u>Cumberland, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 7, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsburgh, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alweisman</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18



6342

CERTIFICATE OF DEATH

Reg. Dist. No.

06346

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Rt. # 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Bedford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>6</u> / Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania, Bedford Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton Brotemarkle</u>				14. MOTHER'S MAIDEN NAME <u>Mary Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Nellie Taylor 311 Pulaski St., Cumb. Md.</u> <u>Patient's chart.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Arteriosclerosis - Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-16</u> , 19 <u>58</u> to <u>6-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-25</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William P. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>441 N. Centre St. Baltimore, Md.</u> DATE SIGNED <u>6-26-58</u>			
PHYSICIAN'S NAME (Type) <u>William P. Jones</u>				<u>Cumberland Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Pike nr. Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6343

## CERTIFICATE OF DEATH

Reg. Dist. **06347**

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>12 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>RT. #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>M</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>11</b> Year <b>1958</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 30</b>		9. AGE (In years last birthday) yrs. <b>63</b>	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MIDLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>CHARLES RICE</b>				14. MOTHER'S MAIDEN NAME <b>MARY EDWARDS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis genl</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Stomach</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>several Mo.</b> <b>? 12 Mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 30</b> , 19 <b>58</b> , to <b>JUNE 11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JUNE 11</b> , 19 <b>58</b> , and that death occurred at <b>10:05 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>		DATE SIGNED <b>6/17/58</b>	
PHYSICIAN'S NAME (Type) <b>A. J. MIRKIN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E S Boal</b>				ADDRESS <b>Westernport Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 17 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS, COUNTY OF DALLAS

DEATH CERTIFICATE

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6344

## CERTIFICATE OF DEATH

Reg. Dist. No.

06348

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>02</u> <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart</u>		d. STREET ADDRESS <u>316 Park Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Celia</u> Middle <u>Mae</u> Last <u>Kaylor</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Thomas, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Dornon</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Barker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Eugene Oxier</u>		Address <u>Ridgeley, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma cervix c</u> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis metastases generalized</u> DUE TO (c) <u>intestinal obstruction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/3</u> 19 <u>58</u> to <u>6/9</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6/9/58</u> 19 <u>58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. George M. Simons</u> M.D. <u>128 W. Main St</u>		<u>6/1/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. George M. Simons</u>		<u>Cumberland, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Burial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Deauch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06349

Reg. Dist. No.

6395

FOR STATE  
HEALTH DEPT.

M

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Picardy Rural</u> c. LENGTH OF STAY IN 1b <u>X Rural Picardy Md.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) _____ d. STREET ADDRESS _____		
<b>3. NAME OF DECEASED</b> (Type or print) <u>John</u> First <u>H.</u> Middle <u>Kenney</u> Last <b>4. DATE OF DEATH</b> <u>June</u> Month <u>20</u> Day <u>1958</u> Year			<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1903</u> <b>9. AGE</b> (In years last birthday) <u>55</u> yrs. <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Cumberland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>13. FATHER'S NAME</b> <u>James Kenney</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Clara Taylor</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>Police</u> Address <u>Cumb. Md.</u>			<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO (b) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> _____ <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____		
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour _____ a. m. _____ p. m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitaralic</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> _____ <b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitaralic</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>22a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>6/24/58</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Allegany Co. Cem.</u> <b>22d. LOCATION</b> (City, town, or county) <u>Cumb.</u> (State) <u>Md.</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Louis Stein Inc.</u> <b>ADDRESS</b> <u>Cumb. Md.</u> <b>24a. REC'D BY REGISTRAR</b> <u>ALL</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>ALL</u>			<b>DATE</b> <u>JUN 26 '58</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06350

6345

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>7 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>53 BOONE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDGAR</b> Middle <b>T.</b> Last <b>KOLB</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 2, 1898</b> 9. AGE (In years last birthday) <b>59</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>FREDERICK KOLB</b>		14. MOTHER'S MAIDEN NAME <b>KATTY COOK SHAFFER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes War I</b>		16. SOCIAL SECURITY NO. <b>705-05-4611</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>2 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 25, 1958</b> , to <b>June 2, 1958</b> , that I last saw the deceased alive on <b>June 2, 1958</b> , and that death occurred at <b>8:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		ADDRESS (Street, city or town, state) <b>236 W. 1st St. Cumberland, Md.</b> DATE SIGNED <b>6/3/58</b>	
PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-6-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 5 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>99 Narrows Park - Cumb, Md</b>		c. LENGTH OF STAY IN 1b <b>10 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>99 Narrows Park - Cumberland, Md</b>		d. STREET ADDRESS <b>99 Narrows Park</b>	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>Dicken</b> Last <b>Lashley</b>		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 23, 1877</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired railroad laborer Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Robert Lashley</b>		14. MOTHER'S MAIDEN NAME <b>Dorcas Robinette</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Rhoda Lashley</b>		Address <b>Cumberland, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Enlarged prostate necessitating catheter drainage</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>3 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 12, 1958</b> to <b>June 9, 1958</b> , that I last saw the deceased alive on <b>June 6, 1958</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. W. TREVASKIS, Jr</b>		DATE SIGNED <b>6/11/58</b>	
PHYSICIAN'S NAME (Type) <b>R. W. TREVASKIS, JR</b>		<b>Cumberland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUN 12 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Leach</b>	



CERTIFICATE OF DEATH

1944

Name of Deceased [REDACTED]		Date of Death [REDACTED]	
Sex [REDACTED]		Age [REDACTED]	
Race [REDACTED]		Place of Birth [REDACTED]	
Usual Residence [REDACTED]		Date of Birth [REDACTED]	
Cause of Death [REDACTED]		Date of Death [REDACTED]	
Place of Death [REDACTED]		Date of Death [REDACTED]	
Name of Physician [REDACTED]		Signature of Physician [REDACTED]	
Name of Coroner [REDACTED]		Signature of Coroner [REDACTED]	
Name of Registrar [REDACTED]		Signature of Registrar [REDACTED]	



## CERTIFICATE OF DEATH

Reg. Dist. No.

6347

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>6 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL-WARWICK AND MEMORIAL AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1009 VIRGINIA AVE.	
3. NAME OF DECEASED (Type or print) First <b>TERRY</b> Middle <b>Alan</b> Last <b>LEWIS</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>8</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 18, 1956</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		9. AGE (In years last birthday) <b>1</b> yrs. IF UNDER 1 YEAR: Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. IF UNDER 24 HRS.		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>CARLTON LEWIS</b>			
14. MOTHER'S MAIDEN NAME <b>DOROTHY JEAN BRINKMAN</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pleural Fistula</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>R. Lobar Pneumonia (Streptococcus)</b> DUE TO (c) <b>8 days.</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>6-2-58</b> to <b>6-8-58</b> , that I last saw the deceased alive on <b>6-8-58</b> , and that death occurred at <b>5:20 PM</b> , from the causes and on the date stated above.			
21. ACTUAL SIGNATURE <b>H. W. Eliason</b> M.D. <b>126 Wm St</b> ADDRESS (Street, city or town, state) <b>Cumberland, Md</b> DATE SIGNED <b>6/10/58</b>				PHYSICIAN'S NAME (Type) <b>DR. H. W. ELIASON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1997

111

52:14

NO. 10-11-12

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6348

## CERTIFICATE OF DEATH

Reg. Dist. No. **06353**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>327 City View Terrace</b>				d. STREET ADDRESS <b>327 City View Terrace</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Allard Lowery</b>				4. DATE OF DEATH Month Day Year <b>June 22, 1958 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1880</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Silk</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Lowery</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Kirk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-07-9640</b>		17. INFORMANT Address <b>Mrs Jessie Lowery, 327 City View Terr. Cumb.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-vascular Disease</b> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 - 22, 19 58</b> to <b>6 - 22, 19 58</b> , that I last saw the deceased alive on <b>6 - 22, 19 58</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Greene St.</b> DATE SIGNED <b>6-23-58</b>							
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>				M.D. <b>62 Greene St.</b>			
PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin</b>				M.D. <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 25, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Charles L. George, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		35		Jan 15, 1920		St. Louis, Mo.	
Cause of Death		Disease		Symptoms		Time of Death		Physician	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		10:00 AM		Dr. J. Smith	
Occupation		Education		Marital Status		Religion		Burial Place	
Teacher		High School		Married		Catholic		St. Mary's Cemetery	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6380

## CERTIFICATE OF DEATH

Reg. Dist. No.

06354

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>A.</b> Last <b>MANN</b>		4. DATE OF DEATH Month <b>6</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watch Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Piney Grove, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Millard Filmore Mann</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Virginia Creek</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMATION <b>Mr. Donald McNeil, 29 Bank St., Carneige, Pa.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Dilatation</b> <b>422.2</b> DUE TO <b>Chr myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> (c) <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 8, 1958</b> to <b>June 8, 1958</b> , that I last saw the deceased alive on <b>June 8, 1958</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>WomcLane</b> M.D.		ADDRESS (Street, city or town, state) <b>Frostburg</b> DATE SIGNED <b>June 10 1958</b>	
PHYSICIAN'S NAME (Type) <b>WomcLane MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ronald H. Mount</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. L. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

FILE NO.

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE

TIME

PLACE

STATE OF MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

STREET OF BALTIMORE

APARTMENT OF BALTIMORE

ROOM OF BALTIMORE

FLOOR OF BALTIMORE

SECTION OF BALTIMORE

WARD OF BALTIMORE

PARISH OF BALTIMORE

CHURCH OF BALTIMORE

SCHOOL OF BALTIMORE

LIBRARY OF BALTIMORE

MUSEUM OF BALTIMORE

GALLERY OF BALTIMORE

THEATRE OF BALTIMORE

CINEMA OF BALTIMORE

STADIUM OF BALTIMORE

AMPHITHEATRE OF BALTIMORE

CONCERT HALL OF BALTIMORE

GRAND BALLROOM OF BALTIMORE

RECEPTION HALL OF BALTIMORE

RESTAURANT OF BALTIMORE

BAR OF BALTIMORE

CLOTHING STORE OF BALTIMORE

SHOES STORE OF BALTIMORE

HAT STORE OF BALTIMORE

GLOVE STORE OF BALTIMORE

COAT STORE OF BALTIMORE

TRUNK STORE OF BALTIMORE

UMBRELLA STORE OF BALTIMORE

WALKER STORE OF BALTIMORE

CANES STORE OF BALTIMORE

WATCH STORE OF BALTIMORE

JEWELRY STORE OF BALTIMORE

TOBACCO STORE OF BALTIMORE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film 6231 7-8-58 et

6381

CERTIFICATE OF DEATH

06355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS <b>State Street</b>	
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>A.</b> Last <b>McCONNELL</b>		4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8th. 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>24</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work Own Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES ALLERDICE</b>		14. MOTHER'S MAIDEN NAME <b>Jamima Allerdice</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. LENARD WOYNICZ, LONACONING, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>20 days -</b> <b>Years -</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 30, 1958</b> to <b>June 24, 1958</b> , that I last saw the deceased alive on <b>June 23, 1958</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>315 ROADWAY</b> DATE SIGNED <b>John B. Davis, M.D.</b>			
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D. Frostburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/27/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		24a. REC'D BY REGISTRAR <b>LONACONING, MD.</b>	
24b. REGISTRAR'S SIGNATURE <b>DATE JUN 30 '58</b>			



6349

CERTIFICATE OF DEATH

Reg. Dist. No. 06356

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>	
c. LENGTH OF STAY IN lb <b>4/30/58</b>		d. STREET ADDRESS <b>Allegany County Infirmary</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>McCormick</b> Last <b>McCormick</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/1873</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Coal Mining</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Barton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph McCormick</b>		14. MOTHER'S MAIDEN NAME <b>Jane Matheison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>453.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Thrombo-angiitis obliterans</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Swelling of lower legs</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/30/58</b> , 19 <b>58</b> , to <b>6/15/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/14/58</b> , 19 <b>58</b> , and that death occurred at <b>11:00 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>6/16/58</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b> <b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Samuel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. S. Bval - Western front, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 20 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlauch</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06357

Items 8 &amp; 9 Film 6350 7/18/58 GTE

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>222 Schley St.,</b>		d. STREET ADDRESS <b>109 Frederick St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLIE</b> Middle <b>McFARLAND</b> Last <b>McFARLAND</b>		4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1880</b> <b>Dec. 21, 1879</b> 77 78 yrs.
9. AGE (In years last birthday) <b>77 78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Everett, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Andrew McFarland</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Leader</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>211-18-1104</b>	
17. INFORMANT <b>Mrs. Roy McFarland</b>		Address <b>Everett, Penna.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 24, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/27/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Providence Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Everett, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 26 '58</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06358**

**6396**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cresaptown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cresaptown</b>	
c. LENGTH OF STAY IN 1b <b>20 years</b>		d. STREET ADDRESS <b>Residence, Cresaptown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary McKee</b>		4. DATE OF DEATH <b>June 10 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Cullen</b>		14. MOTHER'S MAIDEN NAME <b>Mary MCKENZIE Mckenzie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Helen Durr, Cresaptown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Coronary Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 years</b> (c)		INTERVAL BETWEEN ONSET OF DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 - 6</b> , 19 <b>58</b> , to <b>6 - 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6 - 10</b> , 19 <b>58</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>		ADDRESS (Street, city or town, state) <b>62 Greene St.</b>	
PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin M.D.</b>		DATE SIGNED <b>6-11-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 12, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUN 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

44

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# 1 M 60 I 0 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 6351 6351 06359 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN 1b 1 1/2 HRS. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES., d. STREET ADDRESS 111 WEST MARY ST., XXXX e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Lost CLARA Genevieve MERRITT 4. DATE OF DEATH Month Day Year JUNE 12 19 58 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH DEC. 24, 1908 9. AGE (In years last birthday) 49 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland, 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME FREDERICK H. BEAR 14. MOTHER'S MAIDEN NAME KATHERINE WOODNER 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No, 16. SOCIAL SECURITY NO. None 17. INFORMANT Mr. Roy L. Merritt 111 W. Mary St., Cumb. Md. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Metastatic Carcinoma - Pulmonary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Rectum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 mos 6 years 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 1952 to 12 June 1958, that I last saw the deceased alive on 12 June 1958, and that death occurred at 9:23 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James B. Stegmaier M.D. 122 So Centre St., Cumberland 12 June 58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) J. STEGMAIER 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6/14/58 22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery 22d. LOCATION (City, town, or county) (State) Cumberland, Md. 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Maryland 24a. REC'D BY REGISTRAR DATE JUN 16 '58 24b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06360

6397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>X Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Charlestown Street</b>		d. STREET ADDRESS <b>Charlestown Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>METZ</b> Last <b>METZ</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25th.</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20th, 1880, 78rs.</b>
9. AGE (In years last birthday) <b>78rs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner Coal Mine</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Metz</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Lease</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Raymond Metz, Lonaconing, MD.</b>	
17. INFORMANT <b>Mr. Raymond Metz, Lonaconing, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident (SON)</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 days</b> (c) <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 25, 1958</b> to <b>June 25, 1958</b> , that I last saw the deceased alive on <b>June 25, 1958</b> , and that death occurred at <b>1 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>MAIN ST</b> DATE SIGNED <b>6-27-58</b>	
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR. M.D.</b>		<b>LONACONING MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/28/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>		ADDRESS <b>LONACONING, MD.</b>	
24a. REC'D BY REGISTRAR <b>June 26 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Qu...</b>	



THE UNIVERSITY OF CHICAGO

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• **ENVIRONMENTAL**



6382

## CERTIFICATE OF DEATH

Reg. Dist. No.

06361

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN 1b <u>8 Wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				d. STREET ADDRESS <u>Box 54</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>E.</u> Last <u>MICHAELS</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Savage</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Peter Rarick</u>				14. MOTHER'S MAIDEN NAME <u>Emma Lou Lafferty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. John Davis, Box 54, Eckhart, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 5, 1958</u> , to <u>June 2, 1958</u> , that I last saw the deceased alive on <u>June 1, 1958</u> , and that death occurred at <u>6:15 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Mc Lane</u> M.D.				ADDRESS (Street, city or town, state) <u>Frostburg</u> DATE SIGNED <u>June 4, 1958</u>			
PHYSICIAN'S NAME (Type) <u>W. Mc Lane</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Winters</u> ADDRESS <u>23 E. Main, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al L. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6398

## CERTIFICATE OF DEATH

Reg. Dist. No.

06362

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>F.</b> Last <b>MICHAELS</b>		4. DATE OF DEATH Month <b>6</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-27-1869</b>	9. AGE (In years lost birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jeweler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harmon Michaels</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Herman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. John Davis, Eckhart, Md. (Daughter)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>580x Acute Hepatitis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>					
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>June 3, 1958</b> to <b>June 13, 1958</b> , that I last saw the deceased alive on <b>June 11, 1958</b> and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>6-14-58</b> ACTUAL SIGNATURE <b>WOM Lane</b> M.D. <b>WOM Lane</b> PHYSICIAN'S NAME (Type) <b>WOM Lane</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-16-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery Frostburg, Md.</b>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b> ADDRESS <b>23 E. Main, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eckhart Flat</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E.</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-4-1888</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Pajama factory</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John E. Elrick</b>				14. MOTHER'S MAIDEN NAME <b>Isabell Sturtz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>212-01-9798</b>			
				17. INFORMANT Address <b>Mrs. Marguerite Glotfelty, Frostburg, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) <b>5 yrs -</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days -</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 1953</b> to <b>June 8, 1958</b> , that I last saw the deceased alive on <b>June 7, 1958</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Broadway, Frostburg, Md.</b> DATE SIGNED <b>6/9/58</b> ACTUAL SIGNATURE <b>John B. Davis</b> M.D. PHYSICIAN'S NAME (Type) <b>John B. Davis, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-10-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b> ADDRESS <b>Frostburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

10

1000

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Date of birth</p>		<p>4. Place of birth</p>	
<p>5. Date of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Signature of informant</p>		<p>12. Date of registration</p>	
<p>13. Signature of registrar</p>		<p>14. Date of registration</p>	
<p>15. Signature of registrar</p>		<p>16. Date of registration</p>	
<p>17. Signature of registrar</p>		<p>18. Date of registration</p>	
<p>19. Signature of registrar</p>		<p>20. Date of registration</p>	
<p>21. Signature of registrar</p>		<p>22. Date of registration</p>	
<p>23. Signature of registrar</p>		<p>24. Date of registration</p>	
<p>25. Signature of registrar</p>		<p>26. Date of registration</p>	
<p>27. Signature of registrar</p>		<p>28. Date of registration</p>	
<p>29. Signature of registrar</p>		<p>30. Date of registration</p>	
<p>31. Signature of registrar</p>		<p>32. Date of registration</p>	
<p>33. Signature of registrar</p>		<p>34. Date of registration</p>	
<p>35. Signature of registrar</p>		<p>36. Date of registration</p>	
<p>37. Signature of registrar</p>		<p>38. Date of registration</p>	
<p>39. Signature of registrar</p>		<p>40. Date of registration</p>	
<p>41. Signature of registrar</p>		<p>42. Date of registration</p>	
<p>43. Signature of registrar</p>		<p>44. Date of registration</p>	
<p>45. Signature of registrar</p>		<p>46. Date of registration</p>	
<p>47. Signature of registrar</p>		<p>48. Date of registration</p>	
<p>49. Signature of registrar</p>		<p>50. Date of registration</p>	
<p>51. Signature of registrar</p>		<p>52. Date of registration</p>	
<p>53. Signature of registrar</p>		<p>54. Date of registration</p>	
<p>55. Signature of registrar</p>		<p>56. Date of registration</p>	
<p>57. Signature of registrar</p>		<p>58. Date of registration</p>	
<p>59. Signature of registrar</p>		<p>60. Date of registration</p>	
<p>61. Signature of registrar</p>		<p>62. Date of registration</p>	
<p>63. Signature of registrar</p>		<p>64. Date of registration</p>	
<p>65. Signature of registrar</p>		<p>66. Date of registration</p>	
<p>67. Signature of registrar</p>		<p>68. Date of registration</p>	
<p>69. Signature of registrar</p>		<p>70. Date of registration</p>	
<p>71. Signature of registrar</p>		<p>72. Date of registration</p>	
<p>73. Signature of registrar</p>		<p>74. Date of registration</p>	
<p>75. Signature of registrar</p>		<p>76. Date of registration</p>	
<p>77. Signature of registrar</p>		<p>78. Date of registration</p>	
<p>79. Signature of registrar</p>		<p>80. Date of registration</p>	
<p>81. Signature of registrar</p>		<p>82. Date of registration</p>	
<p>83. Signature of registrar</p>		<p>84. Date of registration</p>	
<p>85. Signature of registrar</p>		<p>86. Date of registration</p>	
<p>87. Signature of registrar</p>		<p>88. Date of registration</p>	
<p>89. Signature of registrar</p>		<p>90. Date of registration</p>	
<p>91. Signature of registrar</p>		<p>92. Date of registration</p>	
<p>93. Signature of registrar</p>		<p>94. Date of registration</p>	
<p>95. Signature of registrar</p>		<p>96. Date of registration</p>	
<p>97. Signature of registrar</p>		<p>98. Date of registration</p>	
<p>99. Signature of registrar</p>		<p>100. Date of registration</p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6384

## CERTIFICATE OF DEATH

06364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>30 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. STREET ADDRESS <b>318 EAST MAIN</b>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>LOWERY</b> Last <b>MINNICKS</b>				4. DATE OF DEATH Month <b>6</b> Day <b>15</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-1907</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Store</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland</b>	
13. FATHER'S NAME <b>John Edward Minnicks</b>				14. MOTHER'S MAIDEN NAME <b>Adeline Lowery</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>W. War II 214-07-4418</b>		17. INFORMANT <b>Mrs. Katherine G. Minnicks</b>	
				Address <b>Frostburg, Md. 318 E. Main,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute Coronary Occlusion myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery Heart Disease</b> DUE TO (c) <b>4 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery Disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>MARCH</b> , 19 <b>57</b> , to <b>JUNE 15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JUNE 11</b> , 19 <b>58</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Martin H. Rothstein M.D.</b>				ADDRESS (Street, city or town, state) <b>48 BROADWAY</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>MARTIN H. ROTHSTEIN M.D. FROSTBURG, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-18-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ECKHART, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<b>Paul H. Winters 23 E. Main, Frostburg, Md.</b>				DATE <b>JUN 20 '58</b>		<b>Overleach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6352

## CERTIFICATE OF DEATH

06365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>230 Massachusetts Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Mitchell</b> Last <b>Mitchell</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Restaurant Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(Asia Minor) Turkey</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ernest Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Sylvia Alexoudi</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>P. O. BOX 599</b>		Address <b>Cumberland, Md.</b>	
<b>ALLEGANY COUNTY INFIRMARY RECORDS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Sclerosis</b> DUE TO (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>General Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>4 yrs.</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right Hemiplegia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 25, 1954</b> , to <b>June 12, 1958</b> , that I last saw the deceased alive on <b>June 11, 1958</b> , and that death occurred at <b>4:52 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene Street</b> DATE SIGNED <b>James E. McLean</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		DATE SIGNED <b>June 16 '58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-14-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>June 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6325

Resident of

City

County

Age

Sex

Color

Marital

Occupation

Education

Religion

Place of Birth

Date of Birth

Place of Birth

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6354

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>6/6/55</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ann</b> Last <b>O'Rourke</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/16/1873</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Midland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick O'Rourke</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Caven</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> 593x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Chronic Nephritis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/6/55</b> , 19___, to <b>6/1/58</b> , 19___, that I last saw the deceased alive on <b>5/31/58</b> , 19___, and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>6/2/58</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b> <b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/4/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Michaels</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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...and the ...

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6355

## CERTIFICATE OF DEATH

Reg. Dist. No. 06368

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>12 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL- MEMORIAL AVE.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2 CUMBERLAND</b> d. STREET ADDRESS <b>444 SEYMOUR STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CARLTON</b> Middle <b>RANDALL</b> Last <b>POLAN</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>7</b> Year <b>1958</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 27, 1957</b>	9. AGE (In years last birthday) yrs. <b>8</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>CARLTON POLAN</b>				
14. MOTHER'S MAIDEN NAME <b>NORMA BALLOU</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				
16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Heart Disease</b> DUE TO (c) <b>8 months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>492x Pneumonia - Pulmonary</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>June</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 7</b> , 19 <b>58</b> , and that death occurred at <b>2:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>133 Va Ave, Cumberland, Md 6/8/58</b> PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-9-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			
22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2025

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6385

## CERTIFICATE OF DEATH

Reg. Dist. No. 06369

1. PLACE OF DEATH a. COUNTY <b>Notts* Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md/</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>25 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>49 Depot Terrace</b>				d. STREET ADDRESS <b>49 Depot Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Pollock</b> Last <b>Pollock</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 4, 1872</b>		9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Morris</b>				14. MOTHER'S MAIDEN NAME <b>Sarlitzy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>0</b>		17. INFORMANT <b>June Pollock Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Heart disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C failure.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>None</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 14, 19 58</b> to <b>June 17, 19 58</b> that I last saw the deceased alive on <b>June 14, 19 58</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 BROADWAY</b> DATE SIGNED ACTUAL SIGNATURE <b>John B. Davis, M.D.</b> PHYSICIAN'S NAME (Type) <b>John B. Davis, MD Frostburg, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. Boul</b>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. L. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.











# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06371

Reg. Dist. No.

6400

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 4, Cumberland</u>		c. LENGTH OF STAY IN 1b <u>26 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 4, Cumberland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Christie Road</u>			d. STREET ADDRESS <u>Christie Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLETUS ELLSWORTH PRICE</u>			4. DATE OF DEATH Month Day Year <u>June 15, 19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>45 yrs.</u>		9. AGE (In years last birthday) <u>45</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steward</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Amer. Legion Post</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William L. Price</u>			14. MOTHER'S MAIDEN NAME <u>Josephine Gibbs</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, na, or unknown) (If yes, give war or dates of service) <u>Yes WW2 &amp; Korean</u>		16. SOCIAL SECURITY NO. <u>214 05 5413</u>	17. INFORMANT Address <u>Mary M. Price Route 4, Cumberland, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 18, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight, Cumberland, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>JUN 18 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. K. Smith</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—DIVISION OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <u>JOSEPHINE E. BROWN</u>		AGE <u>40</u>
SEX <u>F</u>		RACE <u>White</u>
DATE OF DEATH <u>June 15, 1933</u>		PLACE OF DEATH <u>Home</u>
CITY <u>West Virginia</u>		COUNTY <u>Jefferson</u>
STATE <u>West Virginia</u>		ZIP <u>26060</u>
MARRIAGE <u>Married</u>		EDUCATION <u>High School</u>
OCCUPATION <u>Housewife</u>		RELIGION <u>Catholic</u>
CAUSE OF DEATH <u>Heart Disease</u>		MANNER OF DEATH <u>Natural</u>
SIGNATURE OF PHYSICIAN <u>Dr. J. H. Brown</u>		DATE <u>June 15, 1933</u>
SIGNATURE OF MEDICAL EXAMINER <u>Dr. J. H. Brown</u>		DATE <u>June 15, 1933</u>
PLACE OF INTERMENT <u>St. Mary's Cemetery</u>		CITY <u>West Virginia</u>
STATE <u>West Virginia</u>		COUNTY <u>Jefferson</u>
ZIP <u>26060</u>		

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06372

6356

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>64 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.</b>				d. STREET ADDRESS <b>FORT ASHBY</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALICE M. PYLES</b>				4. DATE OF DEATH Month Day Year <b>JUNE 16 1958</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 15, 1889</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.,</b>	
13. FATHER'S NAME <b>BENJAMIN CORBIN</b>				14. MOTHER'S MAIDEN NAME <b>LAVERNIA URICE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1958</b> to <b>June 1958</b> , that I last saw the deceased alive on <b>June 6, 1958</b> , and that death occurred at <b>10:17 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>DR. OVERTON HIMMELWRIGHT</b>				ADDRESS (Street, city or town, state) <b>1330a Ave, Cumberland, Md</b>		DATE SIGNED <b>6/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Ashby W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overton</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6386

## CERTIFICATE OF DEATH

Reg. Dist. No.

06373

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>Allegheny</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. STREET ADDRESS <b>1461 Orator Street</b>	
3. NAME OF DECEASED (Type or print) <b>PAUL</b> First <b>LOUIS</b> Middle <b>REIHMS</b> Last		4. DATE OF DEATH Month <b>6</b> Day <b>2</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-1901</b>
9. AGE (In years lost birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance Supervisor</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburgh</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Reihms</b>		14. MOTHER'S MAIDEN NAME <b>Anna Clousen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>168-03-2291</b>	
17. INFORMANT <b>Mrs. Clara Reihms</b>		Address <b>Pittsburgh 4, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 days</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>5-31</b> , 19 <b>58</b> to <b>6-2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-2</b> , 19 <b>58</b> , and that death occurred at <b>7:15 A.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>H.C. Diehl</b> M.D. <b>39 W. Main St.</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>6/2/58</b> PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D., Frostburg, Ind.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>6-5-58</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Memorial Park</b> 22d. LOCATION (City, town, or county) (State) <b>Allegheny County, Pa.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>B.H. Watesant</b> ADDRESS Home <b>23 E. Main, Frostburg, Md.</b> 24a. REC'D BY REGISTRAR <b>JUN 6 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6387

## CERTIFICATE OF DEATH

06374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>4½ days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>JANE</b> Last <b>REPHANN</b>		4. DATE OF DEATH Month <b>6</b> Day <b>8</b> Year <b>19 58.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1886</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Coal City, Illinois.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert White</b>		14. MOTHER'S MAIDEN NAME <b>Jane Nesbit</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Alfred Rephann, 38 Uhl St., Frostburg, Md.</b>		Address (Husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage.</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension arteriosclerosis</b> DUE TO <b>Uterine Fibroid</b> (c) <b>12 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of breast - Complete mastectomy 9 yrs. ago</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-4</b> 19 <b>58</b> , to <b>6-8</b> 19 <b>58</b> , that I last saw the deceased alive on <b>6-8</b> 19 <b>58</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H.C. Diehl</b> M.D.		ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>6/9/58</b>	
PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>		<b>FROSTBURG, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Benjamin H. Montecant</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8227

DATE OF DEATH

DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

DATE OF DEATH

PLACE OF DEATH

REGISTRATION

100

DATE OF DEATH

DECEASED

DECEASED

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06375

6357

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYSER</b> 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>		d. STREET ADDRESS <b>BOX #17.</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>DALE</b> Last <b>RILEY</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>19 58.</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 21, 1958.</b>
9. AGE (In years last birthday) yrs. <b>13</b>		IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min. <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>KEYSER, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>RICHARD O. RILEY</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA JUDY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>- CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Palpable Abscess</b> <b>756.2</b> DUE TO <b>Intestinal Perforation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Multiple Atresia (Intestinal)</b> (c) <b>13 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital Heart Defect</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23, 1958</b> to <b>June 3, 1958</b> , that I last saw the deceased alive on <b>June 3, 1958</b> , and that death occurred at <b>8:40 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DR. XXXXXXXXXX</b>		ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>June 3, 58</b>	
PHYSICIAN'S NAME (Type) <b>DR. XXXXXXXXXX D. B. GROVE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-5-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Point</b>		22d. LOCATION (City, town, or county) (State) <b>Keyser W. Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas R. Smith</b>		ADDRESS <b>Keyser W. Va</b>	
24a. REC'D BY REGISTRAR <b>JUN 9 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Va</b>	

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2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6388

CERTIFICATE OF DEATH

Reg. Dist. No.

06376

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart Mines, Frostburg, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>G.</b> Last <b>Rizer</b>		4. DATE OF DEATH Month <b>6</b> Day <b>30</b> Year <b>1958</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-3-1880</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Simon Rizer</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-9883</b>		17. INFORMANT <b>Mrs. Timothy Thomas, Eckhart Mines, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Cerebral Hemorrhage</b> DUE TO (b) <b>Cerebral arterial sclerosis</b> DUE TO (c) <b>Myocardial Dilatation</b>				INTERVAL BETWEEN ONSET AND DEATH <b>23 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Dilatation (2) Pulmonary Edema.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>6/22</b> , 19 <b>58</b> , to <b>6/30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/30</b> , 19 <b>58</b> , and that death occurred at <b>6:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26 W. Mechanic St. Frostburg, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Frank T. Harra</b> M.D.							
PHYSICIAN'S NAME (Type) <b>FRANK T. HARRAT M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-3-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Mattingly</b> ADDRESS <b>Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>JUL 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6389

CERTIFICATE OF DEATH

Reg. Dist. No.

06377

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>41 W. Main St.,</b>		d. STREET ADDRESS <b>1 41 W. Main St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>C.</b> Last <b>ROBERTS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mathias Rodda</b>		14. MOTHER'S MAIDEN NAME <b>Ann Hicks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Richard MacMannis, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Myocarditis</b> DUE TO (c) <b>Senility</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-22</b> , 19 <b>58</b> , to <b>6-29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-29</b> , 19 <b>58</b> , and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>W. Main St.,</b> DATE SIGNED ACTUAL SIGNATURE <b>H. C. Diehl,</b> M.D. <b>Frostburg, Md.</b> PHYSICIAN'S NAME (Type) <b>H. C. Diehl, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-1-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 2 1958</b>	
ADDRESS <b>Frostburg, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

CERTIFICATE OF DEATH

1930

BALTIMORE

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of sanitarian	
28. Signature of health officer		29. Signature of coroner		30. Signature of jury	
31. Signature of medical examiner		32. Signature of pathologist		33. Signature of anatomist	
34. Signature of bacteriologist		35. Signature of virologist		36. Signature of epidemiologist	
37. Signature of public health nurse		38. Signature of health visitor		39. Signature of sanitarian	
40. Signature of health officer		41. Signature of coroner		42. Signature of jury	
43. Signature of medical examiner		44. Signature of pathologist		45. Signature of anatomist	
46. Signature of bacteriologist		47. Signature of virologist		48. Signature of epidemiologist	
49. Signature of public health nurse		50. Signature of health visitor		51. Signature of sanitarian	
52. Signature of health officer		53. Signature of coroner		54. Signature of jury	
55. Signature of medical examiner		56. Signature of pathologist		57. Signature of anatomist	
58. Signature of bacteriologist		59. Signature of virologist		60. Signature of epidemiologist	
61. Signature of public health nurse		62. Signature of health visitor		63. Signature of sanitarian	
64. Signature of health officer		65. Signature of coroner		66. Signature of jury	
67. Signature of medical examiner		68. Signature of pathologist		69. Signature of anatomist	
70. Signature of bacteriologist		71. Signature of virologist		72. Signature of epidemiologist	
73. Signature of public health nurse		74. Signature of health visitor		75. Signature of sanitarian	
76. Signature of health officer		77. Signature of coroner		78. Signature of jury	
79. Signature of medical examiner		80. Signature of pathologist		81. Signature of anatomist	
82. Signature of bacteriologist		83. Signature of virologist		84. Signature of epidemiologist	
85. Signature of public health nurse		86. Signature of health visitor		87. Signature of sanitarian	
88. Signature of health officer		89. Signature of coroner		90. Signature of jury	
91. Signature of medical examiner		92. Signature of pathologist		93. Signature of anatomist	
94. Signature of bacteriologist		95. Signature of virologist		96. Signature of epidemiologist	
97. Signature of public health nurse		98. Signature of health visitor		99. Signature of sanitarian	
100. Signature of health officer		101. Signature of coroner		102. Signature of jury	

DR. ~~XXXX~~ FAW

6358

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>30 DAYS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>RFD. #3, BEDFORD ROAD</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDGAR</b> Middle <b>WILLIAM</b> Last <b>SEE</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>1958</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 10 1897</b>		9. AGE (In years last birthday) <b>60</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millworker, EVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND North Branch</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathaniel P. See</b>				14. MOTHER'S MAIDEN NAME <b>CORA STICKLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>218-16-2638</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, MEMORIAL &amp; WARWICK STS.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>561.1</b> <i>Uremia and toxic myocardial failure</i> DUE TO <i>Intestinal obstruction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Intestinal obstruction</i> DUE TO (c) <i>Femoral hernia, left</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic nephritis and pyelonephrosis Right kidney hyp</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b> <b>5 days</b> <b>28 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 30</b> , 19 <b>58</b> , to <b>June 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 24</b> , 19 <b>58</b> , and that death occurred at <b>4:09 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>June 24</b> ACTUAL SIGNATURE <b>W. M. Fawcett</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. W. F. FAW</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/26/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 26 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Redman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

ON, WEEK END

NAME OF DECEASED: [illegible]

AGE: [illegible] SEX: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF INTERMENT: [illegible]

PLACE OF INTERMENT: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF SIGNATURE: [illegible]

OFFICE OF REGISTRAR: [illegible]

STATE OF MASSACHUSETTS

CITY OF BOSTON

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

100 NORTH STREET, BOSTON, MASS.

TELEPHONE: [illegible]



6359

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>GRANT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>20 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RACHEL</b> Middle <b>ANN</b> Last <b>SELF</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 20, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA Lahamville</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALEMIA KEPLINGER</b>		14. MOTHER'S MAIDEN NAME <b>AMELIA DAVIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma both lungs, probable original site lesion pyloric end stomach</b> DUE TO (b) <b>a</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease, class 3</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>18 July</b> , 19 <b>57</b> , to <b>21 June</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>20 June</b> , 19 <b>58</b> , and that death occurred at <b>5:55 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b>		ADDRESS (Street, city or town, state) <b>122 S. Centre St Cumberland, Md</b>	
PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>		DATE SIGNED <b>21 June 58</b>	
22a. BURIAL, CREMATION, REMAINS (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-23-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Ashby W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06380

6360 Item 8 Filing 230 6-27-58 et

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>51 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>Young</b> Last <b>SELL</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>20</b> Year <b>19 58</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 28, 1899</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Silk</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>L. JEFFERSON SELL (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>RACHAEL WINTERS (DECEASED)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-6386</b>		17. INFORMANT <b>PATIENTS CHART</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>malignant hypertension</b> <b>445x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>15 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 19, 19 58</b> to <b>June 20, 19 58</b> , that I last saw the deceased alive on <b>June 19, 19 58</b> , and that death occurred at <b>1:55 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b> DATE SIGNED <b>6/21/58</b> ACTUAL SIGNATURE <b>R. W. Trevaskis, Sr.</b> M.D. <b>R. W. Trevaskis, Sr.</b> PHYSICIAN'S NAME (Type) <b>R.W. TREVASKIS, SR.</b> <b>220 BALTIMORE AVE., CUMBERLAND, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6390

## CERTIFICATE OF DEATH

Reg. Dist. No. 06381

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>12 Hill Street</b>			
3. NAME OF DECEASED (Type or print) <b>Wilhelmina</b> First Middle Last <b>Sevinsky</b>				4. DATE OF DEATH Month <b>6</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-1907</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ocean, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Seib</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Holtsohneider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Frostburg, Md.</b> <b>Mr. Joseph Sevinsky, 12 Hill St., (Son)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.4</b> IMMEDIATE CAUSE (a) <b>Hypertension</b> DUE TO <b>acute Cardiac Dilatation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 days</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>1957</b> , 19____, to <b>June 27, 1958</b> , that I last saw the deceased alive on <b>June 27, 1958</b> , and that death occurred at <b>12:01 P.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>WOMcLane</b> M.D.				ADDRESS (Street, city or town, state) <b>Frostburg Md.</b> DATE SIGNED <b>June 28 1958</b>			
PHYSICIAN'S NAME (Type) <b>WOMcLane</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-30-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery Frostburg</b>	22d. LOCATION (City, town, or county) (State) <b>Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Montean</b> ADDRESS <b>Hafer Funeral Home 23 E. Main, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>Alb. Leach</b> DATE <b>JUL 1 '58</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1900

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. Name of Deceased

2. Age at Death

3. Sex

4. Race

5. Date of Death

6. Time of Death

7. Place of Death

8. Cause of Death

9. Duration of Illness

10. Name of Physician

11. Name of Undertaker

12. Name of Burial Place

13. Name of Interment Place

14. Name of Registrar

15. Name of County

16. Name of State

17. Name of City

18. Name of Town

19. Name of Ward

20. Name of Block

21. Name of Lot

22. Name of Grave

23. Name of Monument

24. Name of Marker



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6361 Item 9 File #230 6-20-58 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

06382

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>10/29/49</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Franklin</b> Last <b>Shoemaker</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown Approx.</b>
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR: Months <b>36</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Worked</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. VA. Lost City</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hezekiah N. Shoemaker</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ryan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. BOX 599 Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Chronic Myocarditis</b> DUE TO <b>Congenital muscular dystrophy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 20, 1952</b> , to <b>June 13, 1958</b> , that I last saw the deceased alive on <b>June 13, 1958</b> , and that death occurred at <b>4:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Green Street</b> DATE SIGNED <b>James E. McLean</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		DATE SIGNED <b>June 13, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Allegany County Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>James E. McLean</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

100

06383

6362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Sept., 1951</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				d. STREET ADDRESS <b>131 S. Liberty Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carrie</b>		First Middle Last <b>Shuck</b>		4. DATE OF DEATH Month Day Year <b>June 1, 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/28/1870</b>		9. AGE (In years last birthday) <b>88</b> yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired--Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sewing</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Shuck</b>				14. MOTHER'S MAIDEN NAME <b>Mary Simpkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>P.O. Box 599</b>		Address <b>Cumberland, Md.</b>	
<b>Allegany County Infirmary Records</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Chronic Nephritis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Deterioration</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/1951</b> , 19____, to <b>6/1/58</b> , 19____, that I last saw the deceased alive on <b>5/31/58</b> , 19____, and that death occurred at <b>3:35 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James E. McLean</b>		ADDRESS (Street, city or town, state) <b>49 Greene St. Md.</b>		DATE SIGNED <b>6/2/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 3 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

VS A15 (4)  
JSM 10/57

VS A15 (4)  
15M 10/57

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6363

## CERTIFICATE OF DEATH

Reg. Dist. No.

06384

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, write name of institution) <b>WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>CASH VALLEY ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>BOY</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>26</b> Year <b>1958</b>											
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 21, 1958</b>		9. AGE (In years lost birthday) yrs. <b>5</b>		IF UNDER 1 YEAR Months <b>5</b>		IF UNDER 24 HRS. Hours <b>5</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>HARRY M. SMITH</b>				14. MOTHER'S MAIDEN NAME <b>BETTY JOANN BROOKS</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MARYLAND</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>773.5</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>5 days.</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Birth Weight 3614g</b>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-21-1958</b> to <b>6-26-1958</b> , that I last saw the deceased alive on <b>6-26-1958</b> , and that death occurred at <b>9:35P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>126 Quoush, Cumberland Md</b> DATE SIGNED <b>6/27/58</b> ACTUAL SIGNATURE <b>H. Eliason</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. H. ELIASON</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-28-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>White Oak Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Deal, Pa.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>								24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>					



CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DECEASED'S RESIDENCE

DECEASED'S OCCUPATION

DATE OF DEATH

TIME

PLACE

AGE

SEX

DECEASED'S RESIDENCE

DECEASED'S OCCUPATION

DECEASED'S RESIDENCE

DECEASED'S OCCUPATION

DECEASED'S RESIDENCE



6364

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>55 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>206 Columbia Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nola</b> Middle <b>Glenn</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 5, 1864</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>George Sellers</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Mower</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ralph Ehrbar</b> Address <b>Cumberland, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Supremacies of age</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-14-19-58</b> to <b>6-4-19-58</b> , that I last saw the deceased alive on <b>6-1-19-58</b> , and that death occurred at <b>3:00 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. F. Williams</b> M.D.				ADDRESS (Street, city or town, state) <b>Cumberland Md.</b> DATE SIGNED <b>6-4-58</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. F. Williams</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>JOHN J. HARRIS</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>1910</b></p>		<p>4. Age: <b>35 years</b></p>	
<p>5. Place of birth: <b>St. Louis, Mo.</b></p>		<p>6. Date of death: <b>1945</b></p>	
<p>7. Cause of death: <b>Heart disease</b></p>		<p>8. Place of death: <b>Home</b></p>	
<p>9. Signature of physician: <b>John J. Harris</b></p>		<p>10. Signature of registrar: <b>John J. Harris</b></p>	
<p>11. Signature of informant: <b>John J. Harris</b></p>		<p>12. Signature of witness: <b>John J. Harris</b></p>	
<p>13. Signature of funeral director: <b>John J. Harris</b></p>		<p>14. Signature of undertaker: <b>John J. Harris</b></p>	
<p>15. Signature of coroner: <b>John J. Harris</b></p>		<p>16. Signature of jury: <b>John J. Harris</b></p>	
<p>17. Signature of jury: <b>John J. Harris</b></p>		<p>18. Signature of jury: <b>John J. Harris</b></p>	
<p>19. Signature of jury: <b>John J. Harris</b></p>		<p>20. Signature of jury: <b>John J. Harris</b></p>	
<p>21. Signature of jury: <b>John J. Harris</b></p>		<p>22. Signature of jury: <b>John J. Harris</b></p>	
<p>23. Signature of jury: <b>John J. Harris</b></p>		<p>24. Signature of jury: <b>John J. Harris</b></p>	
<p>25. Signature of jury: <b>John J. Harris</b></p>		<p>26. Signature of jury: <b>John J. Harris</b></p>	
<p>27. Signature of jury: <b>John J. Harris</b></p>		<p>28. Signature of jury: <b>John J. Harris</b></p>	
<p>29. Signature of jury: <b>John J. Harris</b></p>		<p>30. Signature of jury: <b>John J. Harris</b></p>	
<p>31. Signature of jury: <b>John J. Harris</b></p>		<p>32. Signature of jury: <b>John J. Harris</b></p>	
<p>33. Signature of jury: <b>John J. Harris</b></p>		<p>34. Signature of jury: <b>John J. Harris</b></p>	
<p>35. Signature of jury: <b>John J. Harris</b></p>		<p>36. Signature of jury: <b>John J. Harris</b></p>	
<p>37. Signature of jury: <b>John J. Harris</b></p>		<p>38. Signature of jury: <b>John J. Harris</b></p>	
<p>39. Signature of jury: <b>John J. Harris</b></p>		<p>40. Signature of jury: <b>John J. Harris</b></p>	
<p>41. Signature of jury: <b>John J. Harris</b></p>		<p>42. Signature of jury: <b>John J. Harris</b></p>	
<p>43. Signature of jury: <b>John J. Harris</b></p>		<p>44. Signature of jury: <b>John J. Harris</b></p>	
<p>45. Signature of jury: <b>John J. Harris</b></p>		<p>46. Signature of jury: <b>John J. Harris</b></p>	
<p>47. Signature of jury: <b>John J. Harris</b></p>		<p>48. Signature of jury: <b>John J. Harris</b></p>	
<p>49. Signature of jury: <b>John J. Harris</b></p>		<p>50. Signature of jury: <b>John J. Harris</b></p>	
<p>51. Signature of jury: <b>John J. Harris</b></p>		<p>52. Signature of jury: <b>John J. Harris</b></p>	
<p>53. Signature of jury: <b>John J. Harris</b></p>		<p>54. Signature of jury: <b>John J. Harris</b></p>	
<p>55. Signature of jury: <b>John J. Harris</b></p>		<p>56. Signature of jury: <b>John J. Harris</b></p>	
<p>57. Signature of jury: <b>John J. Harris</b></p>		<p>58. Signature of jury: <b>John J. Harris</b></p>	
<p>59. Signature of jury: <b>John J. Harris</b></p>		<p>60. Signature of jury: <b>John J. Harris</b></p>	
<p>61. Signature of jury: <b>John J. Harris</b></p>		<p>62. Signature of jury: <b>John J. Harris</b></p>	
<p>63. Signature of jury: <b>John J. Harris</b></p>		<p>64. Signature of jury: <b>John J. Harris</b></p>	
<p>65. Signature of jury: <b>John J. Harris</b></p>		<p>66. Signature of jury: <b>John J. Harris</b></p>	
<p>67. Signature of jury: <b>John J. Harris</b></p>		<p>68. Signature of jury: <b>John J. Harris</b></p>	
<p>69. Signature of jury: <b>John J. Harris</b></p>		<p>70. Signature of jury: <b>John J. Harris</b></p>	
<p>71. Signature of jury: <b>John J. Harris</b></p>		<p>72. Signature of jury: <b>John J. Harris</b></p>	
<p>73. Signature of jury: <b>John J. Harris</b></p>		<p>74. Signature of jury: <b>John J. Harris</b></p>	
<p>75. Signature of jury: <b>John J. Harris</b></p>		<p>76. Signature of jury: <b>John J. Harris</b></p>	
<p>77. Signature of jury: <b>John J. Harris</b></p>		<p>78. Signature of jury: <b>John J. Harris</b></p>	
<p>79. Signature of jury: <b>John J. Harris</b></p>		<p>80. Signature of jury: <b>John J. Harris</b></p>	
<p>81. Signature of jury: <b>John J. Harris</b></p>		<p>82. Signature of jury: <b>John J. Harris</b></p>	
<p>83. Signature of jury: <b>John J. Harris</b></p>		<p>84. Signature of jury: <b>John J. Harris</b></p>	
<p>85. Signature of jury: <b>John J. Harris</b></p>		<p>86. Signature of jury: <b>John J. Harris</b></p>	
<p>87. Signature of jury: <b>John J. Harris</b></p>		<p>88. Signature of jury: <b>John J. Harris</b></p>	
<p>89. Signature of jury: <b>John J. Harris</b></p>		<p>90. Signature of jury: <b>John J. Harris</b></p>	
<p>91. Signature of jury: <b>John J. Harris</b></p>		<p>92. Signature of jury: <b>John J. Harris</b></p>	
<p>93. Signature of jury: <b>John J. Harris</b></p>		<p>94. Signature of jury: <b>John J. Harris</b></p>	
<p>95. Signature of jury: <b>John J. Harris</b></p>		<p>96. Signature of jury: <b>John J. Harris</b></p>	
<p>97. Signature of jury: <b>John J. Harris</b></p>		<p>98. Signature of jury: <b>John J. Harris</b></p>	
<p>99. Signature of jury: <b>John J. Harris</b></p>		<p>100. Signature of jury: <b>John J. Harris</b></p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6365

## CERTIFICATE OF DEATH

06386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN TB <b>19 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>POTOMAC PARK</b>	
3. NAME OF DECEASED (Type or print) <b>BABY BOY STEIN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>27</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 8, 1958</b>
9. AGE (In years last birthday) yrs. <b>19</b>		IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. STEIN</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH E. GOLLADAY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>340.3</b> <b>Meningitis - Type not known</b> DUE TO (b) <b>14 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12, 1958</b> , to <b>June 27, 1958</b> , that I last saw the deceased alive on <b>June 27, 1958</b> , and that death occurred at <b>4:16 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>133 Va Ave, Cumberland, Md 6/27/58</b>	
PHYSICIAN'S NAME (Type) <b>DR. O. HIMMELWRIGHT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/28/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memo Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		ADDRESS <b>Cumb. Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: JOHN J. HENRY

AGE: 65

RESIDENCE: POTOMAC PARK

DATE OF DEATH: APR 11 1954

PLACE OF DEATH: CHESAPEAKE, MARYLAND

CAUSE OF DEATH: HEART DISEASE

DECEASED'S SIGNATURE: JOHN J. HENRY

DECEASED'S ADDRESS: POTOMAC PARK

DATE OF BIRTH: APR 11 1889

DATE OF DEATH: APR 11 1954

DATE OF BURIAL: APR 11 1954

DATE OF INTERMENT: APR 11 1954

DATE OF CREMATION: APR 11 1954

DATE OF EXHUMATION: APR 11 1954

DATE OF REINTERMENT: APR 11 1954

DATE OF REINTERMENT: APR 11 1954

DATE OF REINTERMENT: APR 11 1954

DATE OF REINTERMENT: APR 11 1954

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6391 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	c. LENGTH OF STAY IN lb <b>life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>ALBERT</b> Last <b>STOTT</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-29-1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>23</b> Hours <b>1958</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired maintenance-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West. Md. R. R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Stott</b>		14. MOTHER'S MAIDEN NAME <b>Laura Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-03-7413</b>	
17. INFORMANT <b>Mrs. Nellie P. Stott, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>974X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hanging</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home (woods)</b>		20f. (City or town) (County) (State) <b>Frostburg alleg. Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 24</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-26-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

FOR STATE  
DEATH TEST

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
6301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. OCCUPATION <i>Teacher</i>		5. MARITAL STATUS <i>Married</i>		6. PLACE OF BIRTH <i>Maryland</i>	
7. DATE OF DEATH <i>Jan 15 1961</i>		8. TIME OF DEATH <i>10:00 AM</i>		9. PLACE OF DEATH <i>Home</i>	
10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF EXAMINER <i>[Signature]</i>	
13. SIGNATURE OF WITNESS <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	



## 6366 CERTIFICATE OF DEATH

06388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md. 02</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>38 Elder St.</b>				d. STREET ADDRESS <b>38 Elder St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma</b>		First <b>Virginia</b>		Middle <b>Twigg</b>		Last	
4. DATE OF DEATH <b>6 - 6 - 58</b>		Month		Day		Year <b>19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1862</b>		9. AGE (In years last birthday) yrs. <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ownho me</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert F. Twigg</b>				14. MOTHER'S MAIDEN NAME <b>Christina Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles Twigg</b>			
				Address <b>Cumberland, Md. 38 Elder</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>18 mo.</b> <b>20 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced age</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 14, 1956</b> to <b>June 6, 1958</b> , that I last saw the deceased alive on <b>June 6, 1958</b> , and that death occurred at <b>5:30 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James P. Hallinan</b>		ADDRESS (Street, city or town, state) <b>M.D. 140 Bedford Street</b>				DATE SIGNED <b>6-8-58</b>	
PHYSICIAN'S NAME (Type) <b>James P. Hallinan 140 Bedford St. Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-10-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1956

MASSACHUSETTS

<p>1. Name of deceased: <u>James P. Sullivan</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>April 1, 1908</u></p>		<p>4. Place of birth: <u>Worcester, Mass.</u></p>	
<p>5. Date of death: <u>April 1, 1956</u></p>		<p>6. Place of death: <u>Worcester, Mass.</u></p>	
<p>7. Cause of death: <u>Myocardial infarction</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>April 1, 1956</u></p>		<p>12. Office of registration: <u>Worcester, Mass.</u></p>	

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
100 NORTH ST.  
BOSTON, MASS.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06389**

**6367**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>× Rt. # 1 Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D. O. A. Sacred Heart Hosp.</b>		d. STREET ADDRESS <b>Box 732 Mt. Savage Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>BELL</b> Last <b>TWIGG</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2,</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1874</b>
9. AGE (in years last birthday) <b>83</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Spring Gap, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Amos Davis</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Little</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ruth E. Smith Rt. # 1 Box 732 Cumb. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/4/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Near Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		24a. REC'D BY REGISTRAR <b>JUN 4 '58</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10



10

FOR STATE  
HEALTH DEPT.

6401

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LITTLE ORLEANS</b>		c. LENGTH OF STAY IN lb <b>LIFETIME</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LITTLE ORLEANS</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LITTLE ORLEANS</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT RANDOLPH TWIGG</b>		4. DATE OF DEATH Month Day Year <b>JUNE 28, 19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 21, 1913</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTMASTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. P.O.</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WARREN L. TWIGG</b>		14. MOTHER'S MAIDEN NAME <b>MYRTLE RICE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW 11</b>		16. SOCIAL SECURITY NO. <b>217-18-4669</b>	
17. INFORMANT <b>MRS. LENA T. TWIGG, LITTLE ORLEANS, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. SKITARELIC</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY 2, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		22d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. HAFFER, CUMBERLAND, MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 3 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>June 28, 1958</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 06391

6368

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>6/16/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emory</b> Middle <b>Lloyd</b> Last <b>White</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/1877</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired--Crystal Laundry Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Algernom M. White</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Carpenter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214 05 9026</b>	
17. INFORMANT <b>P. O. Box 599</b> Address <b>Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> DUE TO <b>592x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO <b>?</b> (c) <b>Chronic Nephritis</b> DUE TO <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Deterioration</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/16/58</b> , 19____, to <b>6/21/58</b> , 19____, that I last saw the deceased alive on <b>6/20/58</b> , 19____, and that death occurred at <b>7:05A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b>		ADDRESS (Street, city or town, state) <b>49 Greene St.</b>	
DATE SIGNED <b>6/21/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 24, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

CERTIFICATE OF DEATH

Name of Deceased Alfred W. White		Sex Male		Age 30	
Date of Death 6/20/50		Place of Death Home		Cause of Death Heart Disease	
Occupation Factory Worker		Usual Residence 440 Maryland Avenue		Manner of Death Natural	
County Baltimore		City Baltimore		State Maryland	
Date of Birth 6/20/20		Place of Birth Maryland		Race White	
Marital Status Single		Education High School		Religion Roman Catholic	
Signature of Physician Dr. James A. Holman		Signature of Coroner Dr. James A. Holman		Signature of Registrar Dr. James A. Holman	
Signature of Deceased Alfred W. White		Signature of Next of Kin Mrs. M. White		Signature of Burial Director Dr. James A. Holman	
Signature of Burial Director Dr. James A. Holman		Signature of Burial Director Dr. James A. Holman		Signature of Burial Director Dr. James A. Holman	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06392**

6369

FOR STATE  
HEALTH DEPT.

M

60

I

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Tenn.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>46hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. STREET ADDRESS <b>Second &amp; C. Sts.</b>	
3. NAME OF DECEASED (Type or print) <b>Douglas Lowell Wilds</b>		4. DATE OF DEATH <b>June 16 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1936</b>
9. AGE (In years last birthday) <b>22 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pvt. U.S. Marines</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Armed Forces</b>	
13. BIRTHPLACE (State or foreign country) <b>Newport, Tenn.</b>		14. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
15. FATHER'S NAME <b>Jake M. Wilds</b>		16. MOTHER'S MAIDEN NAME <b>Oran McClure</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		18. SOCIAL SECURITY NO.	
19. INFORMANT <b>Mrs. Elizabeth Wilds</b>		Address <b>Newport, Tenn.</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Maceration of brain</b> <b>825x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Skull Fracture</b> DUE TO (c)</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <b>848 hrs.</b></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>10 June 14 58</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Near Romney, W. Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 16, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/17/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Newport Tenn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Lewis</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(1933)

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		Jan 15, 1933		Home	
Cause of Death		Disease		Symptoms		Manner of Death		Occupation		Education	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		Natural		Farmer		High School	
Time of Death		Place of Death		Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
10:00 AM		Home		[Signature]		[Signature]		[Signature]		[Signature]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6370

## CERTIFICATE OF DEATH

Reg. Dist. No. 06393

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	c. LENGTH OF STAY IN lb <b>2/15/58</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Corriganville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eliza</b> Middle <b>Jeanette</b> Last <b>Winebrenner</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Sherwood</b>		14. MOTHER'S MAIDEN NAME <b>Frances Henderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>		18. <b>Allegany County Infirmary Records</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Chronic Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Deterioration</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from <b>2/15/58</b> , 19____, to <b>5/17/58</b> , 19____, that I last saw the deceased alive on <b>5/17/58</b> , 19____, and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.		
ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <b>James E. McLean</b> (M.D.) <b>49 Greene St.</b>		<b>6/17/58</b>
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>June 19, 1958</b>	<b>Porta Cemetery</b>	<b>Hardman, Pa. PA 1</b>
23. FUNERAL DIRECTOR'S SIGNATURE		24. REC'D BY REGISTRAR	
<b>Harvey D. Zeigler</b>		<b>JUN 20 1958</b>	
ADDRESS		25. REGISTRAR'S SIGNATURE	
<b>Hardman, Pa.</b>		<b>Chas. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6371

## CERTIFICATE OF DEATH

Reg. Dist. No.

06394

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>02</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 N. Centre St</u>		d. STREET ADDRESS <u>710 N. Centre St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Harriet</u> Last <u>Youngblood</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18, 1905</u>
9. AGE (In years (last birthday)) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Scottsdale Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Zeller</u>		14. MOTHER'S MAIDEN NAME <u>Anna Fletcher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>14601 100 000000</u>	
17. INFORMANT <u>Helen Youngblood</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 30, 1950</u> to <u>June 3, 1958</u> that I last saw the deceased alive on <u>June 3, 1958</u> and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>49 Green St</u> DATE SIGNED <u>6/4/58</u>			
ACTUAL SIGNATURE <u>L.B. Mathews</u> M.D.		DATE SIGNED <u>6/4/58</u>	
PHYSICIAN'S NAME (Type) <u>L.B. Mathews, M.D.</u>		<u>Cumberland Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/5/58</u>	<u>St. Patrick's Ch.</u>	<u>Cumb. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Jan 15 1910</i>	
5. PLACE OF DEATH <i>Home</i>		6. CITY <i>Baltimore</i>		7. COUNTY <i>Harford</i>		8. STATE <i>Md.</i>	
9. OCCUPATION <i>Farmer</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. DISEASE OR INJURY <i>Myocarditis</i>		12. MEDICAL HISTORY <i>None</i>	
13. SIGNATURE OF PHYSICIAN <i>John Doe</i>		14. SIGNATURE OF WITNESSES <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	

106277

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06395**

**6372**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1 yr-4 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>			d. STREET ADDRESS <b>309 Washington Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Elizabeth</b> Last <b>Zehner</b>			4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1884</b>		9. AGE (In years last birthday) <b>74</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			13. FATHER'S NAME <b>Emanuel B. Erdman</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Dimmick</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mrs. John L Sammel</b> Address <b>Cumberland, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Rosemont Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Bloomsburg</b>		22e. (State) <b>Penna</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 16 '58</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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